Welcome to Liverpool Physical Therapy

Patient Information

Name: _____SSN: _____ Date of Birth: _____

Address: _____E-Mail _____ Home Phone: _____

City_____ State_____ Zip Code_____ Work Phone: _____

Employer: _____ Occupation: _____ Cell Phone: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact: _____Relation to Patient:_____ Phone: _____

Insurance Information

*Primary Insurance Company: _____ Phone: _____

Policy Holder Name (if different than above): _____ ID#: _____

SSN:_____ Date of Birth: _____CoPay (if known): $_____

*Secondary Insurance Company: _____ Phone: _____

Policy Holder Name (if different than above): _____ ID#: _____

SSN: _____ Date of Birth: _____

HIPAA *Documentation*

* I acknowledge that I have been given the opportunity to read and/or receive a copy of Liverpool Physical Therapy's Privacy Notice.

Leave appointment messages on:

Answering Machine?	Y N
Cell Phone?	Y N
Office Voice Mail?	Y N
W/Person Listed Below?	Y N

Leave other medical/Insurance Info on:

Answering Machine?	Y N
Cell Phone?	Y N
Office Voice Mail?	Y N
w/Person Listed Below?	Y N

Person(s) authorized to discuss the above: Any person(s) at home phone #: Y N

_____ _____

_____ _____

* Signature: _____ Date: _____

** I consent to have the Practice use and disclose my protected health information for payment, treatment, and health care operations purposes, and for such other purposes that are permitted under HIPAA

* Signature: _____ Date: _____

Financial Agreement

☐ Participating Insurance Plans ☐ Workers Compensation/No Fault Insurance

Liverpool Physical Therapy is a participating provider with your insurance plan. As a participating provider we will accept their payment as payment in full with the exception of co-payments, co-insurances, deductibles, and non-covered services as determined by your contract. Patients are responsible for determining if physical therapy (or Nerve Conduction/EMG testing) is covered by your insurance plan. Co-payments are determined by your contract and are due at time of service. Co-insurance is the percentage due by you based on your insurance contract. Your deductible is the amount due by you before any insurance benefits will be paid. You must check with your insurance carrier for your particular benefits. Co-insurances and deductibles are billed to you once payment is received from your insurance carrier. These amounts are due upon receipt of bill. Additionally, any service charges or collection agency/legal fees incurred in the collection process will be the responsibility of the patient.

Liverpool Physical therapy is required to bill your insurance carrier directly for medical treatment received in relation to a work related injury or automobile accident. However, it is your responsibility to provide our office with the necessary information(insurance company, claim number, contact person, etc.) to receive prompt payment. You will be notified of any insurance rejection or problem. Information not supplied by you may result in a rejection of your claim. Should your claim be denied, you are responsible for payment in full. If this occurs, arrangements should be made immediately with our billing staff.

I have read, understand, and agree to the above agreement and I authorize the payment of my medical benefits to Liverpool Physical Therapy for services and products rendered.

Signature: _____ Date: _____

Tell us how you heard about us

Which PT Office?	Phone Book	Dr. List	Dr. Recommendation	Friends & Family	Internet	Insurance Company	Drove- By	Former Patient of Joanne's
Liverpool PT								
Barry And VanBeveran								

Health History

Patient's Name: _____ Date: _____

Do you now or have ever had any of the following:

Diabetes	_____Yes _____No	Allergies to heat	_____Yes _____No
High Blood Pressure	_____Yes _____No	Allergies to ice	_____Yes _____No
Heart Disease	_____Yes _____No	Other Allergies	_____Yes _____No
Heart Attack	_____Yes _____No	Previous Surgery	_____Yes _____No
Pacemaker/Defibrillator	_____Yes _____No	Hernia	_____Yes _____No
Headaches	_____Yes _____No	Seizures	_____Yes _____No
Kidney Problems	_____Yes _____No	Metal Implants	_____Yes _____No
Nervous Disorders	_____Yes _____No	Dizziness	_____Yes _____No
Are you Pregnant?	_____Yes _____No	Cancer	_____Yes _____No

If you have answered yes to any of the above please explain and give appropriate dates:

_____

Are you presently taking medication? _____Yes _____No If yes, please list your medications and/or for what condition:

_____

_____